TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Azalea Orthopedics

Respondent Name
National Liability & Fire Insurance

MFDR Tracking Number
M4-16-3356-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
July 05, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Reasoning for why the disputed fees should be paid: The carrier denied procedure 20670 F1 as a duplicate, and paid 20670 F2. It is the provider's position that this is in error. Implant removal was performed on 2 different fingers, and this is documented in the op notes."

Amount in Dispute: $1,035.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the bills in question were escalated and the review has been finalized. Our bill audit company has determined no further payment is due."

Response Submitted by: Gallagher Bassett, 6404 International Parkway, Suite 2300, Plano, TX 75093

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 22, 2016	20670, F1	$1,035.00	$285.15

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 18 – Duplicate claim/service
   - W3
   - 193

Issues

1. Is the carrier's denial supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier denied the disputed service as 18 – "Duplicate claim/service." Review of the submitted medical claims for the date of service in dispute finds code 20670- F1 and 20670- F2. Review of the "Operative Report" shows, "The two K-wires were removed from the index and long finger." The carrier's denial is not supported as separate procedures is supported by the modifiers utilized and the supporting documentation. The service in dispute will be reviewed per applicable rules and fee guidelines.
2. 28 Texas Administrative Code §134.203 (c)(1) states in pertinent part,

   To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor). For Surgery when performed in a facility setting, the established conversion factor to be applied is (date of service yearly conversion factor).

The maximum allowable reimbursement is calculated as follows:

DWC Conversion Factor / Medicare Conversion Factor x Medicare Fee Schedule or $71.32/$35.8043 x $143.15 = $285.15.

3. The maximum allowable for the service in dispute is $285.15. The carrier previously paid $0.00. The remaining balance of $285.15 is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $285.15.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $285.15, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		August , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.